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ABSTRACT

This manual was written for both health care professionals and community leaders wishing to work together to enhance the availability of culturally appropriate health care services for refugees. The material is also relevant to people who wish to develop the sensitivity and skill needed to serve any culturally diverse clientele. The booklet describes how hospitals, clinics, and community agencies wishing to enhance the delivery of quality health care in a culturally diverse environment might organize a collaborative cross-cultural training project. A whole-system approach is described: (1) to equip medical interpreters to take on case management responsibilities; (2) to equip "mainstream" hospital and clinic staff to serve refugee patients more effectively; and (3) to increase refugees' knowledge of the health care system. Several community agencies serving limited-English speaking persons, Denver Health and Hospitals staff, and the Denver Mayor's Office of Employment and Training collaborated on the design and implementation of this demonstration training project. An appendix provides an extensive resource list, some networking possibilities, and training partners for cultural awareness and intensive case management. (LL)

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ED 362 521

Delivering Health Care To Refugees

Cross-cultural training to enhance the delivery of quality health care to culturally diverse persons

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Abstract: This manual describes how hospitals, clinics, and community agencies wishing to enhance the delivery of quality health care in a culturally diverse environment might organize a collaborative cross-cultural training project. A whole-system approach is described:

1) to equip Medical Interpreters to take on case management responsibilities;
2) to equip "mainstream" hospital and clinic staff to serve refugee patients more effectively; and
3) to increase refugees' knowledge of the health care system.

Several community agencies serving limited-English speaking persons, Denver Health and Hospitals (DHH) staff, and the Denver Mayor's Office of Employment and Training (MOET), collaborated on the design and implementation of this demonstration training project.

The project was funded by the Office of Refugee Resettlement, U.S. Department of Health and Human Services, through a Targeted Assistance Discretionary Grant.

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Delivering Health Care To Refugees

Cross-cultural training to enhance the delivery of quality health care to culturally diverse persons

David Dunn, Editor

Spring Institute for International Studies
Denver, Colorado

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Cover

A Hmong refugee participant in an intensive cross-cultural training spoke about the necessity for openness to change in bridging between cultures. The bamboo bridge was his image of the flexibility required to avoid being broken by the stress of making one's way to the other side.

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Special acknowledgment must be given to the network of caring people who helped conceive, design and implement the unique cross-cultural training partnership described on the following pages.

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Introduction

Public-private partnership

In 1990, federal Targeted Assistance Discretionary Grants were made available to states and officially designated agencies to mitigate the impact of high concentrations of refugees on human service and educational systems. Denver's Mayor's Office of Employment and Training (MOET) was designated to submit a proposal for Colorado, and the Spring Institute for International Studies was asked to develop a concept and prepare the proposal on MOET's behalf. The grant was approved, and funding flowed from the Office of Refugee Resettlement, to MOET, and then to Denver Health and Hospitals and the Spring Institute. The following manual documents the approaches and learnings of the Project.

Audience—hospitals and communities dealing with diversity

This manual was written for health care professionals and community leaders wishing to work together to enhance the availability of culturally appropriate health care services for refugees. But much of what follows is also relevant to people who wish to develop the sensitivity and skill needed to adequately serve any culturally diverse clientele, including African-Americans, Native-Americans, Americans from Spanish-speaking cultures, and indeed, members of the various immigrant communities who maintain some of the culture and practices of their native countries.

Many people will find this material of interest and value:

- ✓ hospital administrators, including…
  - human resource staff
  - Social Work department directors
  - Staff Development department directors
- ✓ community organizations, including…
  - staff from the community-based, not-for-profit agencies
  - public-sector departments
  - private sector partners with resources and expertise

A manual designed for busy readers

The manual was designed so readers may scan for differing levels of detail:

- ✓ The **Table of Contents** is a brief summary of the entire manual
  - Section headings indicate major project considerations
  - Bulleted items indicate major project learnings;
- ✓ **Bold margin notes** summarize related paragraphs throughout the manual;
- ✓ The **text** provides a detailed description of the approach, training components, and learnings relevant to other institutions and communities.

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Section 1

"With the discovery that refugees are not exotic visiting creatures—that they are in fact long-term neighbors—comes the need for the system to accommodate to provide on-going care."
Jan Reimer, Director, Refugee Health Care Access Program, Colorado

"Whole-system" Framework

Americans have a history of valuing immigration in principle but not always dealing well with the resulting cultural diversity in fact. A case in point is the experience of refugees arriving in the United States during the last decade. Hundreds of public, private, and voluntary sector organizations have helped refugees access services related to housing, employment, counseling, training and health care. Federal funds were made available to help refugees become self-sufficient, and for a period of time in the mid-eighties, refugees were able to access a broad range of federally supported and locally sponsored services.

A turning point in service delivery to a largely unknown population

Now, several years into the '90s, with economic priorities changing and philanthropic dollars shrinking, refugees struggling with unique cultural adjustment issues and with employment, housing, education and health issues just like everyone else, may find themselves in need of special services which are no longer available. Refugees remain a shadow population for many Americans—only partly visible and only partially understood. Providers sensitive to issues of quality assurance and quality of life in a diverse society must face the challenge of providing services to largely unknown people with very special needs.

Refugees entering the mainstream will require providers to offer culturally appropriate services

Federal funding for refugee programs has existed since the passage of the Refugee Act of 1980. The elimination of much of this federal funding over the next few years and competing demands on overburdened state and local budgets are forcing agencies serving refugees to rethink their postures toward partnership and collaboration. Helping refugees enter the mainstream system is now a major issue for health care providers. How can appropriate services needed by people from other cultures be provided by health care systems already stretched to their limits?

Cross-cultural training can help health care providers cope with hard times

The premise of the demonstration project, which was funded by the Office of Refugee Resettlement and implemented with Denver Health and Hospitals staff, was that collaborative cross-cultural training can, a) help refugees make better use of health care services already available to them, and, b) help hospital staff deliver these services more effectively and more efficiently. Refugee patients' difficulty accessing services and staff members' difficulty delivering services can be minimized by helping both refugees and hospital staff understand each other's cultures. The bottom lines: health care providers can save time and money by offering strategically conceived cross-cultural trainings to staff and refugee community members and the community at large can benefit if easier access to health care helps refugees stay well on their journey toward economic self-sufficiency and social self-reliance.

An effective network of service providers, governmental entities, and refugee

Tap the strengths of the community

community groups has been evolving during the past 15 years to serve the 18,000 refugees now living in the Denver metropolitan area. The Denver Health and Hospitals system, the major public health care provider in the Denver area charged with serving residents without regard to their ability to pay, has employed Medical Interpreters since 1982. The Project tapped the strengths of this community-wide human service/health care network.

A multi-faceted approach can impact the whole health care system

The Project called for a multi-faceted approach from the very start, i.e., a training strategy that would address the needs of all the parts of the health care system which impact refugee patients.

- mainstream hospital and clinic staff
- Medical Interpreters employed by Denver Health and Hospitals
- refugee community leaders

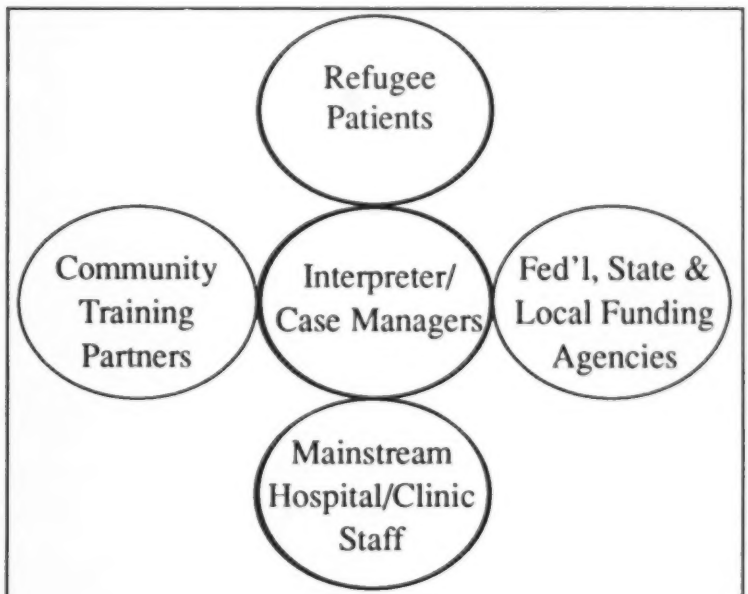
A balanced strategy increases the capacity of the whole system

Cross-cultural training for any one of these groups could have created pressures or expectations within the delivery system which would have been difficult to handle. By working with each of these three parts of the system, a balanced increase in the capacity of the entire system to work with refugees was assured. One central strategy was to enlarge the jobs and increase the capacity of the Medical Interpreters, i.e., to equip them to become Medical Interpreter/Case Managers.

The following pages describe the elements of a "whole-system" approach.

- Cross-cultural orientation for mainstream hospital and clinic staff
- Professional interpreter training for DHH Medical Interpreters
- Case Management training for DHH Medical Interpreters
- Refugee community meetings to share information on health care access

A "whole system" strategy includes not-for-profit and public sector partners



A holistic model of the "Health Care System"

"The Project worked in spite of the system. Everyone enjoyed the process of doing this."
Leslee Offerle, Director, Clinical Social Work, Denver Health & Hospitals

Collaborative Approach

Collaboration has benefits beyond giving a project a competitive edge

Collaboration may seem like an adventure grudgingly undertaken by agencies in hopes of demonstrating acumen and capacity to funders. Even when requests for proposals do not explicitly suggest or require collaborative submissions, there is a growing awareness among service providers that working with agencies who may have been perceived as competitors in the past, may strengthen a proposal for funding. But collaborative motivation can go far beyond the hope of attracting support in a competitive economy.

A complex strategy requires collaboration

In the case of the present cross-cultural training, collaboration was required from the start because of the complexity of funding channels required to get federal dollars to the point of need in the local community. Furthermore, beyond this purely fiscal/accounting necessity, a complex training strategy required collaborative implementation in order to be effective. The following timeline illustrates the phases in the development of the project and the major tasks undertaken at each stage of implementation. On the pages which follow, each of these phases will be described in turn.

A cross-cultural project requires an extended time frame

Project Design / Grant Writing	*Implementation Planning*	*Phased Implementation*
• Decide to collaborate • Develop concept, justification, proposal • Create fiscal roles & mechanisms • Secure approvals & official "sign-offs"	• Track hiring process • Launch planning with implementation team • Create public relations strategy • Conduct needs analysis • Secure continuing education credits • Schedule training sessions	• Cross-cultural training for mainstream staff • Interpreter training for bilingual staff • Intensive case management training for bilingual staff • Health care access training for community • Mentoring for bilingual staff
6 months	**6 months**	**12 months**

Design Phase...

create a system of delegated authority and fiscal responsibility

Notification of the availability of federal Targeted Assistance Grant "Discretionary" funds came from the Colorado Refugee and Immigrant Services Program (CRISP), a division of the Colorado Department of Social Services, in mid-1990. This state agency delegated its authority to receive a discretionary grant to the City and County of Denver, and the city delegated responsibility to the Mayor's Office of Employment and Training (MOET), the JTPA-funding agency under the auspices of Denver's Private Industry Council (PIC). The Spring Institute for International Studies was asked to develop a project concept and write a grant on behalf of the Mayor's Office of Employment and Training.

Four factors are needed to prepare an excellent proposal: decide a lead partner;

Four factors assured the effective submission of the proposal. First, a clear commitment to collaborate from members of Denver's refugee services network was made from the start. The assurance of full participation by all players made it possible for the Spring Institute to work as lead agency on behalf of this larger network in the early stages of conceptualizing the project. In essence, the agency writing the grant became the champion of an inclusive approach on behalf of additional players who would subsequently add specific detail to the implementation plan.

find a champion to help the system work;

The second factor was the presence of a tireless champion on the staff of the Mayor's Office of Employment and Training for making "the system" work. This program specialist on the staff of the fiscal agent was the central catalyst for all the bureaucratic decisions and arrangements required before the grant could be submitted.

obtain comprehensive information;

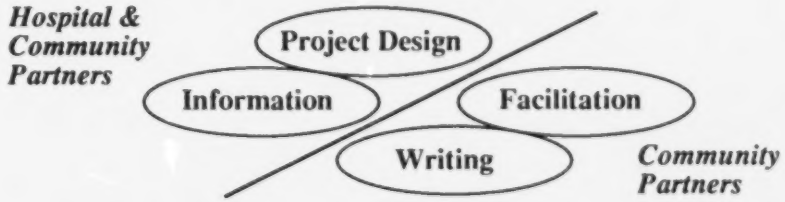
The third factor was the cooperation of staff from the Colorado Department of Health and the Colorado Refugee and Immigrant Services Program. Program specialists were able to provide the inclusive perspective and specific information needed to prepare a well-grounded proposal.

and assure inclusive participation in design.

The fourth factor was the willing participation of the players who would become partners in the project's implementation, i.e., the Director of Clinical Social Work, Denver Health and Hospitals (DHH), and the Executive Director of the Asian Pacific Center for Human Development (who would be co-trainer with Spring Institute staff). Each of these partners contributed specific information, ideas, or approaches to the proposal which was submitted to the Office of Refugee Resettlement.

Four interconnected roles are needed

Collaboration during this preparatory stage requires several interconnected roles. In various settings, partners supply information, think through the Project concept and describe its potential impact. Several "facilitating" roles are required, e.g., acting as project champion, leading meetings, and actually writing the grant on behalf of the larger network. The community partners were able to expedite the project by playing the facilitator and writer roles.



A changing agenda dictates fluid roles

As the Project took shape, attendance at meetings reflected the purpose of planning at that stage. Early on, one-on-one meetings with the grant writer focused on information that described the need for training. Later, partners focused on the broad concepts and the roles which each would play. Finally, as the grant writing was nearing completion, meetings focused on delineating the specific lines of communication and accountability required to satisfy the terms of the grant and the procedures of the collaborating agencies. Bullet points were prepared to succinctly interpret the complex project to the agency heads who would sign off on a submission being prepared by staff.

Implementation Planning Phase...

Once funding was assured, the partners shifted to planning the project's implementation. Denver Health and Hospitals already employed a Vietnamese and Cambodian interpreter. Steps were immediately taken to hire a Lao/Hmong and a Russian interpreter in order to cover the major refugee patient language groups present in the hospital and clinics.

Each part of the strategy builds on what has gone before

It is worth recalling that the Project design called for a four-part training strategy: cross-cultural orientation for mainstream staff, professional interpreter training, case management training for the four Medical Interpreters, and community meetings to provide information on health care access to refugee groups. This approach was taken to build a solid foundation: 1) to address mainstream staff members' questions about cultural issues in health care; 2) to prepare the Medical Interpreters to take on a larger role with their mainstream colleagues; and finally, 3) to address the questions of refugees in the community about how to access services in a system newly prepared to work in more culturally appropriate ways.

Involve Staff Development and Human Resource Management

DHH Staff Development and Human Resource Management staff were invited to join the implementation team. While the Director of Clinical Social Work had been the liaison with the Medical Interpreters during the Project's Design Phase, Nursing Department and HRM staff were essential liaisons with the larger hospital and clinic system during the Implementation Planning phase. Together these three key hospital staff and the training partners translated assumptions made in the Design Phase about staff needs and interests into specific questions for a survey form.

Design a simple needs assessment

Hospital staff advised that a single sheet with fewer than 20 questions and space for comments would receive more attention than a longer questionnaire. The planning team chose this simple format in hopes of a larger response. The survey asked respondents to rank their interest in a series of topics related to cross-cultural concerns on a "1 - 5" Likert rating scale. A plan was devised for broad dissemination of this questionnaire throughout the hospital and neighborhood clinics and respondents were asked to indicate their job classification.

Tell everyone about the Project, the survey and benefits of their participation

The next step in implementation was to introduce the hospital and clinic staff to the proposed cross-cultural trainings and to solicit their participation in the needs assessment. A presentation was made to the Nursing Department Heads and an article was placed in the DHH internal newsletter. Several hundred copies of the needs assessment survey were then distributed with directions to return them to an envelope posted for the purpose on each of the units or to the Clinical Social Work office.

The assessment guides both public relations and training decisions

Results from the needs assessment surveys were tallied and summarized by job category and results presented to the entire implementation team. This information became the basis for creating fliers advertising the cross-cultural trainings and the specific content and examples used during the trainings.

Offering credit and thoughtful scheduling assure maximum participation

During the same time that the needs assessment was being conducted, team members from Staff Development and Human Resource Management were making arrangements for continuing education credits and scheduling training times and locations to facilitate maximum participation by all three shifts. Three time slots were offered: 8–10 a.m. for the night shift, 1–3 p.m. for the evening shift, and 3:30–5:30 p.m. for the day shift. Fliers for each workshop session contained information on content, time, location, and continuing education credits. Interested staff members were asked to make reservations with the DHH Training Office.

Four complementary roles

During the Implementation Planning Phase, the partners began to play more distinct roles. Hospital staff provided liaison with the complex system they knew best. The community training partners began to see the real needs of their future workshop participants and were able to decide the specific content required. Regular coordination meetings were held to keep the entire team abreast of developments. By this stage, anticipation was building for the actual trainings to be begin.

"I understand how they feel, what they are going through, so I am more comfortable with my clients."
See Thao,
Hmong Interpreter,
Denver Health & Hospitals

Training Designs

Implementation Phase...

Training is needed to help the entire health care system cope with cultural issues

A job enlargement strategy creates a core of cross-cultural specialists

Mainstream staff and refugees are taught how to bridge cultural and language barriers

Models were adapted from cross-cultural mental health, case management and interpreter training

Training can be scheduled to permit integration of classroom and on-the-job learning

The Project was developed with the premise that cross-cultural training would materially benefit both the health care system, *per se*, and its refugee patients. Medical Interpreters at DHH have been an important resource in supporting effective health care access by refugee patients since the early 80s. Project funding made it possible to hire additional interpreters and to equip both the health care system and refugee patients to make effective use of these specialized bilingual staff. The overarching goal of the Project was to help the entire health care system, including patients, handle cross-cultural encounters with greater understanding and finese.

To achieve this goal, several training strategies were used. The first was training to facilitate the "enlargement" of the Medical Interpreters' job description. A shift was to be made from understanding the Medical Interpreters as solely linguistic paraprofessionals to understanding them as dual-role professionals with both case management and interpretation functions.

A second strategy involved an orientation to cross-cultural communication in health care settings for mainstream staff members. In essence, mainstream staff were given an introduction to working with refugee patients and guidance on how to effectively use the Interpreter/Case Managers in the process.

A third strategy involved an orientation to the DHH system held for refugee groups throughout the community. In this training refugees were given information to make visits to the hospital and clinics more productive and less stressful.

The Project used models developed by two Denver agencies which serve refugees and provide training and technical assistance to refugee service providers—Spring Institute for International Studies and Asian/Pacific Center for Human Development. Subject matter relevant to general health care settings was drawn from trainings dealing with refugee cultural adjustment, cross-cultural training for bilingual mental health workers, case management and interpretation.

Without contact with refugee patients following training, learning transfer and real practice are greatly diminished. It is a continuing challenge to implement an effective training strategy attuned to the demands of a health care system's real workload. If census is low, staff may be willing to spend more time in the classroom. But, conversely, with fewer refugee patients in attendance, opportunities to practice learnings are limited. Only careful scheduling can provide enough class time for substantial "classroom learning" and at the same time, enough patient contact to assure realistic "floor learning."

In fact, it may be essential to provide a two-part training strategy in which a shorter time is given to the initial training in order to permit follow-up sessions

Funding needs to allow adequate time to conceive, design and implement a comprehensive training strategy

devoted to promoting integration of new content in light of on-the-job experience. In addition, some staff members will wish even further training and these may need to be referred to other resources or be invited to help organize sessions beyond the scope of initial funding. One hopes that funding can allow a project to extend its training strategy over at least an entire year in order to accommodate both numbers of staff and the need for learning transfer. The DHH partners felt that at least two years was an appropriate time frame for implementation of such a project, from the beginning of the design process to the completion of the final trainings.

Multiple training designs make it possible to address an entire system's training needs

The models which follow represent a comprehensive view of images, attitudes and skills needed by health care providers and refugee patients in order to enhance health care access. In delivering these trainings, however, a pragmatic approach was taken. The trainers worked within the real time, space, and attention constraints of the several participant groups.

Time-frame	Training Component	Training Design	Audience	Trainers
May, '91–Aug., '92	*Orientation to Cross-Cultural Awareness*	12, 2–4 hour presentations/ discussions	Mainstream hospital and clinic staff	Spring Institute & Asian/Pacific
Fall, 1991	*Orientation to the Interpreter Role*	2, 4-hour seminars	Bilingual Interpreters	Spring Institute & Asian/Pacific
November, 1991	*Intensive Case Management Training, I*	40 hours; residential	Bilingual Interpreters	Spring, A/P & guest presenters
February, 1992	*Intensive Case Management Training, II*	40 hours; residential	Bilingual Interpreters	Spring, A/P & guest presenters
Fall, '91; Spring & Summer, 1992	*Interpreter/ Case Manager mentoring*	3, 1-3 hour sessions	Bilingual Interpreters	Spring Institute & Asian/Pacific
January, 1992	*Train-the-Trainer Workshops*	2, 3-hour workshops: a) model b) customize	Bilingual Interpreters, refugee leaders	Spring Institute
Dec. '91 – April '92	*Orientation to Health Care Access*	10, 3-hour community meetings	Refugee groups	Biling. Int'rs, A/P & Spring biling. staff, refugee ldrs.

Twelve 2- to 4-hour orientations were conducted for "mainstream" hospital & clinic staff

Orientation to Cultural Awareness for "mainstream" hospital and clinic staff	
Topic	**Method**
Who are the refugees? • Where do they come from? • Why are they here? • What is the refugee experience?	Lecture, facilitated discussion
Concepts of cross-cultural health care for refugees. • How it relates to the environment • The importance of harmony and balance • Coining, cupping, acupuncture, etc.	Lecture, video; facilitated discussion
Expectations for health care • The role of medication • Prescription issues • The patient/provider relationship	Lecture, video; facilitated discussion
Other cultural factors • Abuse & the role of the American medical profession • Family roles ; group vs. individual-oriented cultures • Age and gender issues	Lecture with discussion
Using an interpreter effectively	Lecture, video; facilitated discussion
Rational Objective: increase staff members' awareness of refugees' special needs and values in order to enhance the quality of care delivered. Experiential Objective: support staff with no formal cultural awareness training in working sensitively and confidently with limited English-speaking and/or culturally-diverse patients.	
Resources: overhead slides, handouts, maps, videos Setting: hospital conference room; clinics	

A flexible curriculum was based on the needs assessment but modified to meet unique participant interests

Cultural Awareness Orientation sessions were designed for staff with little or no formal cross-cultural training and were limited to two to four hour sessions to accommodate busy schedules. The needs assessment allowed some tailoring of individual sessions to meet the special interests of specific groups.

Special sessions were organized for hospital social workers; the hospital Ethnics Committee; Pediatric Clinic doctors, nurses, clerical and support staff; staff of neighborhood clinics with a high volume of Southeast Asian patients; and for neighborhood clinic staff interested in Russian culture and health care practices. Sessions were also offered for staff interested in cross-cultural issues with adolescent and elderly patients. Additional special trainings are planned for staff from Ob-Gyn and Geriatric units.

A job enlargement strategy with Medical Interpreters requires role clarification

Orientation to the Interpreter Role			
	Role Image / Engagement with Patient	**Skill**	**Danger**
Interpreter	language & meaning / less "personal" engagement	accurately communicate patient's physical & emotional condition	going too far to interpret the patient's feelings or to act as the patient's advocate
Case Manager	counseling & coordinating / more "personal" engagement	empower the patient to make choices and obtain services	not effectively equipping patients to take responsibility for their own needs
Interpreter/ Case Manager	Flexible "dual-role"/ degree of personal engagement varies	ability to play both roles as needed and to "change hats" easily	not clarifying for both patient and medical professional which role is being played
Issues addressed: • conflict of interest and necessity of candid feedback, e.g., "It's not appropriate for me to translate in this situation." • professionalism, e.g., dealing with patients who ask interpreter for advice • lack of confidence, e.g., working with demanding medical professionals • gender issues, e.g., a male interpreter being asked to deal with gynecological concerns & procedures or a younger female working with an older male			
Rational Objective: Clarify the nature of the Interpreter and Case Manager roles and communicate the effectiveness of the dual role being developed. Experiential Objective: Foster a sense of enthusiasm for the project and confidence to take on new responsibilities.			

Staff learn how to appropriately use Interpreters from the Interpreter/ Case Managers themselves

Medical staff acknowledged both the need for Medical Interpreters to insure effective health care delivery and the difficulty of working with them. Because it was impossible to take sufficient time to orient medical professionals to the art of using interpreters, it was even more important to give the DHH Interpreter/Case Managers thorough training in the interpreter role. The job enlargement strategy began with the workshop outlined above highlighting and clarifying the relationship between interpretation and case management. Communicating the distinction is key to effectively playing either role and hospital staff need appropriate expectations when they work with bilingual workers. The Case Management Intensive Training (see page 11) also contained information and skill-building sessions related to the interpreter role.

The initial forty-hour intensive training transfers basic skills and attitudes and builds confidence to take on a professional role

Case Management Intensive Training - Session I for Bilingual Interpreters		
Day	**Morning**	**Afternoon**
1	• Introduction; needs assessment • Overview • Refugee health issues, trends, concerns • Western concepts of illness & treatment	• Issues in the health care system • Interpreter, consultant, advocate roles • Evaluate the day • Trainer expectations
2	• Western diagnostic practices; cross-cultural issues • Treatment guidelines	• Values clarification • Role play on "intake"
3	• Reasonable counseling goals • Cross-cultural communication • Verbal & non-verbal communication • Counseling techniques	• Crisis intervention • Role play
4	• Burn out; discussion • Problem identification • Client responsibility • Case Manager roles	• Interpersonal styles • Role play
5	• Hospitalization & referrals • Assignment to create "Community Resource Files"	• Preparation for re-entry into the work role • Identify on-going issues
Rational Objectives: learn about cross-cultural health care issues and basic information about the American health care system; develop new skills as medical interpreters and case managers; develop an awareness of patient and staff expectations Experiential Objective: develop confidence for their new professional role		
Resources: two videos—"Peace Has Not Been Made" and "House of the Spirit." See Appendix. Setting: small residential training center		

A small, residential training permits individual attention to each participant's needs

In order to meet the unique needs of the DHH Interpreter/Case Managers, the Case Management Intensive Trainings were modified to include training in counseling and interpreting for both health and mental health service delivery situations. The Interpreter/Case Managers come from varied backgrounds and are asked to play a complex, dual role bridging between the cultures of several professions, hospital and clinics, and refugee patients. A small training group, several trainers, and a residential setting are essential in order to build trust and provide time to address every participant's concerns.

The second intensive training provides the occasion to reflect on recent experience and to explore culturally sensitive topics in depth

Case Management Intensive Training - Session II for Bilingual Interpreters		
Day	**Morning**	**Afternoon**
1	• Discuss experiences since Session I • Discuss Community Resource Files	• Cultural shock & acculturation • Developmental stressors in life-stage crises • Role plays
2	• Family issues: divorce • Intergenerational issues • Alcohol & substance abuse	• Task-oriented case management • Role plays
3	• Human sexuality • Rape	• Health care practices in specific cultures • Role plays
4	• Abuse • Death & dying • Suicide	• Working as an interpreter • Role play
5	• Stress management for bilingual workers • Community capacity building • Networking • Life planning	
Rational Objectives: recognize skills needed in their professional roles and opportunities for practice. Enhance awareness and ability of bilingual workers to serve language groups other than their own. Experiential Objective: increase commitment and poise to practice their new role in increasingly diverse situations.		
Resources: three videos—"Providing Services with an Interpreter," "Refugee Mental Health: Interpreting in Mental Health Settings," and "Task-oriented Case Management." Setting: small, residential training center		

Increased experience and skill make in-depth case studies possible during the second intensive Training week

The first and second sessions of the Case Management Intensive Training are separated by several months to give participants time to practice what they have learned. Participants come to the second session with many questions and their experience becomes grist for intensive case study and discussion. Comparison of simulated patient encounters videotaped during Sessions One and Two documents a dramatic increase in both skill level and confidence and provides opportunity for further learning.

Opportunities for mentoring sustain the momentum of learning

One-on-One Interpreter/Case Manager Mentoring	
Session	**Focus**
1, 2, 3	• Share further information about the community's refugee services network • Share the latest training videos or manuals • Address issues related to refugee health care • Work with specific areas of interest
Rational Objectives: provide alternative opportunities to enhance experiential learning; meet specific needs as they arise between formal workshop sessions. Experiential Objective: sustain a feeling of encouragement and support to try out new roles and responsibilities.	
Setting: Spring Institute, Asian/Pacific, Colorado Refugee and Immigrant Services Program conference rooms, i.e., alternative settings in the community.	

Lead trainers assume the role of community resource brokers

Mentoring sessions were conducted by the two lead trainers with participation from other community agencies. The sessions provide an informal, one-on-one setting in which the Interpreter/Case Managers learn from their on-the-job experiences in dialogue with trainers in their roles as community leaders, agency staff members, and resource brokers.

Two Train-the-Trainer Workshops give bilingual trainers the opportunity to experience a culturally appropriate training

Train-the-Trainer Workshop for Leaders of Native Language Community Meetings
Context: purpose of the training & the role of ethnic trainers • Introductions: name, job • The importance of training refugees to access the hospital & clinic system
What refugees should know to access the DHH system • When & why to go; how to set up an appointment; handling emergencies • What happens at the hospital; appointments • What if a patient doesn't speak English?
Roles of Interpreter/Case Managers in relation to health care access • Interpreters at Denver General Hospital; How to access the Interpreters • What if there is no interpreter for the patient's language?
What does it cost to go to the doctor? • Different kinds and levels of care • Financial status of the patient
Health care differences: United States vs. the native country • Roles of traditional healers and doctors; medication: prescriptions vs. herbs • Need for doctor/patient cross-cultural communication
Getting acquainted with the hospital system • Tour of DGH departments and clinics • Special features of the neighborhood clinics
Planning for the Community Meetings • Dates and locations; finding an appropriate place to meet; role of trainers • Support—videos, training packets • Outreach—native language fliers, mailing, phoning
The training process • Approach—participant-based, team training; plan, set agenda, make handouts • Content—outline, video, Q & A, using handouts • Follow-up—scheduling, training, reporting; next steps
Rational Objectives: model training content, process, and trainer style Experiential Objectives: help participants develop an awareness and affirmation of their gifts as trainers and become confortable with a participative style
Materials: overheads, videos, handouts

...and to develop specific plans appropriate to their community

An Interpreter/Case Manager and a bilingual community leader formed a strong leadership team for each language group's Community Meeting. The Train-the-Trainer session modeled a suggested agenda giving the teams an opportunity to expand their own knowledge, ask questions, and discover the content relevant to their particular community. The training also gave DHH staff an opportunity to raise issues related to refugees' use of hospital and clinic facilities, e.g., inappropriate use of the Emergency Room.

Native-language Community Meetings were held in community settings convenient to refugees

Orientation to Health Care Access Native Language Community Meetings for Refugees
Welcome & Introduction • Meeting purpose; introductions; what care is available & why its important
When to see a doctor or other health worker • The condition or illness; importance of a physical exam; emergencies
How to access services in the hospital or Neighborhood Health Center • Getting advice from the doctor/other health care worker during/after hours • How to schedule appointments; walk-in appointments • When and where to go for a medication refill • Who to talk to if you have problems in hospital or at home
What to bring with you • Hospital card; legal document, I-94; Social Security number; proof of residency; picture ID; emergency contact • Insurance, Medicare/Medicaid card; prepare for co-pay
Being on time; canceling an appointment • Why it is important to let the clinic know: e.g., liability for a charge, to allow scheduling another patient's appointment, no exception for late arrival (except emergencies)
Insurance • How the hospital rates you, how your insurance pays; what you have to pay • Indigent program, private insurance, Medicare & Medicaid; what to do if ineligible for the indigent program
Choosing a doctor • It is important to know your doctor; choose a doctor you are comfortable with • Name, location and telephone number for your doctor; reaching your doctor • Does your doctor take insurance? How to pay if you don't have insurance • Can you trust an intern, i.e., a "trainee doctor?"
Transportation • How to schedule with Red Cross. How to use Medicaid for transportation • Who to talk to if you have problems
Interpreters, Social Worker, Senior Plus Worker • Interpreters from community agencies and DGH • Social Worker & Senior Plus Worker: DGH Dept. of Clinical Social Work
Rational Objective: inform refugees of public health care services available to them and the most effective means for accessing them; establish a personal connection with the Interpreter/Case Managers. Experiential Objective: help refugees develop the trust and courage to make use of available services.
Setting: informal community locations accessible to refugees.

Community Meeting leadership teams of two included one of the DHH Interpreter/Case Managers and a bilingual staff person from the Spring Institute, Asian Pacific Center for Human Development, or the Colorado Refugee Services Program. Many who attended were surprised to learn what services were available.

Notes

"It's more than just translation; it's a need for real communication."
Dr. Ben Gitterman, Director, Ambulatory Pediatric Services, Denver Health & Hospitals

Learning About Culture

Health care employees are willing and able to learn about other cultures

Because Denver General is a trauma facility, the Medical Interpreter/Case Managers work principally with nurses, doctors, clerical, and finance staff in outpatient ambulatory care, the Emergency Room, and Surgery, especially to assist families. To a lesser extent, they work with nursing and dietary personnel on the inpatient floors, and with neighborhood health clinic staff. Like most of America's large, urban, public hospitals, staff in these areas are stretched to the breaking point. Yet 127 out of 200 needs assessment survey forms were returned and over 200 mainstream staff participated in the trainings—a testimony to their willingness to invest time in learning how to care for refugee patients.

Benefits...

Cross-cultural training enlarges the patient care team

Participants in the Cultural Awareness Trainings were given a brief introduction to the unique quality of care concerns among refugees. But new awareness alone could have left mainstream staff frustrated without the availability of the Interpreter/Case Managers as a ready and effective resource. The willingness of mainstream staff to acknowledge refugees' special needs was met with a corresponding willingness on the part of the Interpreter/Case Managers to prepare for new and expanded responsibilities. The impact of training both mainstream and refugee staff members was to create an awareness of a larger patient care team—including cross-culturally skillful, bilingual workers.

Interpreters develop the skills of case management professionals

The Interpreter/Case Managers have begun to acquire the skills of counseling professionals, i.e., how to work systematically, in a step-by-step manner, with patients and staff. Their training resulted in a greater empathy and understanding of patients' problems. They have learned a larger role and a greater repertoire of responses and alternatives to offer patients, including making appropriate referrals. Mainstream staff and patients alike benefit from this increased capacity of Interpreter/Case Managers to function in a professional environment.

Confident bilingual staff extend the capacity of mainstream staff

Before the trainings, some doctors were unwilling to see patients unless each brought his/her own interpreter. Increasing competence has helped the Interpreter/Case Managers develop the confidence to facilitate communication between doctors and patients. Interpreters help doctors communicate with greater clarity and effectiveness by demonstrating how to speak directly to patients, use simpler language, and write directions or draw picture explanations. With knowledge and confidence has come a new ability to work with culturally loaded topics such as sexual assault and suicide. Their presence gives doctors and nurses access to the indirect communication from patients that otherwise might be missed.

Interpreter/Case Managers assure quality care...

Trained Interpreter/Case Managers represent an effective strategy for enhancing quality service delivery to non-English-speaking patients. The Interpreter/Case Managers have improved patient compliance, e.g., there has been an in-

crease in refugee patients following medical instructions, taking medications consistently, and attending well-baby checks.

...and help minimize the system's liability

Enhancing communication with doctors and nurses, a matter of life and death for patients, is no less significant for hospital managers. Interpreter/Case Managers reduce the danger of miscommunication, especially in the emergency and operating rooms. They are an important risk management strategy for hospitals which must necessarily minimize exposure to liability.

Interpreter/Case Managers help assure reimbursement

Quite apart from minimizing future liability, Interpreter/Case Managers are able to save money in the present. Contrary to the fears of some, culturally diverse patients are not always a financial liability; most who show up at Denver General have Medicaid or are eligible for Medicaid. Interpreter/Case Managers help a health care system minimize the loss of possible reimbursement.

Use of Interpreter/Case Managers increases as staff experience cross-cultural assistance

Since the trainings, rising encounter trends indicate that hospital staff have begun to rely more heavily upon the assistance of the Interpreter/Case Managers. Mainstream staff recognize that the Interpreter/Case Managers save time and reduce stress when working with refugee patients. These staff now complain loudly if an interpreter is not available. A provider may wish to create an activity documentation system that allows a Department of Clinical Social Work to track patient encounters and demographics and to quantify time and money saved in serving refugee patients.

Long-term community resources are identified

In addition to the immediate benefits noted above, there are other long-range benefits when leaders in the health care system and community agencies collaborate to offer cross-cultural training to staff members and potential patients. The network of refugee service providers gives hospitals and clinics a practical first entrée to the major refugee communities and thousands of potential patients. Relationships were established with new community resources which can remain active long after the last workshop is held and final report written.

Departments establish closer working ties

Another benefit is the impact on the health care system of having to deal with outsiders in a collaborative venture. Inventing and implementing a project with outsiders gave these three departments an occasion to strengthen working relationships with each other. In effect, the Nursing, Human Resource Management and Clinical Social Work Departments were given an opportunity to move from occasional acquaintance to intensive working rapport.

Challenges...

Collaborating partners can help the health care system deal with unforeseen challenges as they arise

Training Medical Interpreters to add case management functions to their daily routine—and helping mainstream health care and administrative staff members make effective use of these new bilingual workers—is a major organizational development strategy. While project leaders can anticipate many of the benefits and dangers of a development strategy dealing with cultural issues, even the most well-conceived project will have both rough edges and unforeseen consequences. Thus, the most important prerequisite for undertaking a cross-cultural project is a commitment to building an organizational culture that can deal with cultural issues as they arise. The following paragraphs contain a brief description of the challenges which confronted the health care system and its community partners in developing and implementing the project.

Selection Process...

Different does not mean incompetent

How can a personnel department and supervisor effectively guide a multicultural selection process? Hiring "mainstream" workers is sensitive enough these days; hiring persons from dramatically different cultural and language backgrounds is an even greater challenge, because of the danger of equating differences in style and manner of speaking with differences in competence and potential. Bilingual ability is a necessary but not sufficient qualification.

Cross-cultural professionals need both cultural knowledge and language power

Interpreter/Case Managers must have both cross-cultural knowledge and "language power." "Bilingual/bicultural" in a professional context means a person has the ability to use specific knowledge at an appropriate level of fluency in two languages. It is therefore necessary to determine an applicant's education, knowledge, and experience level, as well as whether they are currently literate, in their native language. Help is clearly needed.

Ask a bilingual, bicultural community person to help conduct the selection interview

A culturally and linguistically savvy selection process for hiring Interpreter/Case Managers can be created by asking outside, bilingual/bicultural persons with known qualifications to attend the screening interviews. At DHH, while the Director of Clinical Social Work was the recommending supervisor, a highly trained community person acted as co-interviewer to advise regarding the actual native-language fluency of interviewees and the probability of their working effectively with patients from their cultural background. A health care system which needs to hire bilingual staff will likely have access to both men and women already in the professional and business mainstream who can play this role.

Response Patterns...

Planners need to anticipate differing levels of response

To what extent is it possible to anticipate the level of demand for services by Interpreter/Case Managers? An example will illustrate the challenge.

Several Russian-language community meetings have been held, including one organized by a local library. The hospital has since been inundated with Russian-speaking patients, grateful for the availability of a Russian-speaking person on staff. In contrast, while use of DHH facilities by other language groups has increased following the community meetings, none has increased as dramatically.

Consider cultural factors as well as "pent up need" for services in estimating response patterns

We don't yet understand what caused this uneven response. Does it reflect a different valuing of institutional health care services or differing levels of tolerance for risking a new challenge? What effect does the gender of the Interpreter/Case Managers have on the credibility of their presentations? To what extent were age, educational level and personal presence factors in the effectiveness of the communication? Does the different response simply reflect the relative effectiveness of the informal communication system within each refugee community or differing responses to the public health care facility? It does seem clear that as the credibility and familiarity of the Interpreter/Case Managers increased, they will increasingly receive referrals from other refugee service providers.

The Director of Colorado's Refugee Health Care Access Program notes that different refugee communities may have different levels of "pent up need" for health care services. Methods need to be developed to estimate this relative need and to gauge the probable response to a community orientation to health care access. In order to efficiently use the time of their new Interpreter/Case Managers and plan use of facilities, supervisors need to be prepared to deal with different levels of response by different refugee communities.

Role Definition...

Refugees have experienced violation of personal and cultural boundaries

Any employee appreciates clear job expectations and defined responsibilities, but bilingual workers who have come to the United States as refugees or immigrants are doubly vulnerable in this respect. Their personal boundaries may have been violated in sometimes unspeakable ways and their arrival in a new community and culture has demanded the reworking of much which defined them in the past. Acculturation, the journey of adjustment and settling in to a new culture, can be like dying and being born all at once.

A bilingual worker's empathy is a unique asset for an employer

Most refugees undertake this journey of acculturation with some sense of hope that their lives will not always be so painful. Indeed, the experience of cultural suffering bilingual workers share with their clients can also be a unique asset for their employers. It can contribute both to a bilingual worker's professional empathy and to his or her loyalty to the employer who makes it possible to mitigate this hardship for other members of the community.

Home-culture values and desire to succeed create heavy job pressures

The down side of this shared empathy is, however, the possibility that bilingual workers may be "too" anxious to please, particularly if they are in their first job in a responsible professional role in this country. Some cultures place such a high value on serving and pleasing others, or on achievement and advancement, that the combination of cultural pressure, pressures from their own ethnic community, financial anxiety, and a personal desire to succeed can place a new bilingual worker in the difficult tension of wanting to do anything they are asked to do while being equally afraid of trying tasks with which they are not familiar.

A dual-role, "hybrid" job description has unique values and challenges

The combination of the bilingual medical interpreter and case manager roles, creates a very useful hybrid job description from the point of view of both patients and the health care system. In many respects it is quite natural to combine language and service "facilitation" in this way. But the fact that each role, i.e., interpreter and case manager, is a profession in its own right, creates special challenges for the dual-role professional.

Bilingual staff need help defining their responsibilities and availability

How can supervisors help bilingual staff establish appropriate role expectations ? Such matters can be carefully covered in training, but with real patients and real demands, pressures to overextend oneself are powerful, and careful supervision is needed to help bilingual staff members make appropriate daily choices and then deal with the consequences in their relationships with mainstream colleagues and patients. A number of issues will need consideration.

Supervisors can help bilingual workers practice assertiveness in setting limits

People who supervise bilingual workers must help everyone understand the responsibilities and limits of this new position. Bilingual staff need to practice assertiveness skills and their mainstream co-workers need to practice precise, simple communication. Effective interpreters can help mainstream staff flex to accommodate culturally diverse patients; good supervisors can help bilingual staff flex to create boundaries and limits appropriate to their new roles.

Questions related to job scope must be answered

Should interpreters translate in situations not under the direct supervision of a mainstream professional? If so, under what circumstances? Staff members may be tempted to use the interpreter to translate materials whose use is not directly supervised by a doctor or nurse, thus creating a level of legal exposure for the interpreter and hospital. Technical translation should be handled by a professional translator, not the person in a paraprofessional role assisting a physician or nurse.

Hire professional translators for published materials

A hospital would be well advised to hire a linguistic professional on a consulting basis to translate materials about which there is concern for legal exposure.

Limits need to be set on the availability of interpreter/case managers

Should the Interpreter/Case Managers be obliged to show up when their services are needed during evening or night shifts? As staff members become familiar with the value of competent interpreters, they tend to request them at all hours. The interpreters will be torn by this real demand at work and the demands of their own personal life at home. Lines have to be drawn to guard against burnout and a hospital will need to decide on what basis their interpreters will be called back to work or asked to interpret over the phone. Evening and weekend nursing supervisors can provide a useful screening function. If enough flexibility can be built into regular work hours, Interpreter/Case Managers can take comp time when called out for evening or weekend emergencies.

Interpreter banks can serve additional language groups

Because staff may demand interpretation for patients who speak languages other than those spoken by Interpreter/Case Managers on the payroll, the hospital may need to establish connections with interpreters in the community. Payment mechanisms are needed for "on-call" services. An interpreter bank may be the way staff reach competent interpreters when their bilingual colleagues are not available. Interpreter banks exist in many communities and may be anxious to create formal cooperative agreements with hospitals and clinics.

Bilingual and mainstream staff are a significant working unit needing time and support for continued learning

Interpreter/Case Managers and the mainstream staff with whom they work need time to share on-the-job experiences and the guidance of supportive leaders in encouraging mutual learning. Supervisors need to create opportunities for bilingual workers to receive feedback from mainstream staff. If a busy Director of Clinical Social Work is hard pressed to devote such time, one of the bilingual workers might function as a lead worker under the supervision of an experienced member of the Clinical Social Work staff.

Other Cultural Groups...

African-American, Native-American, and Hispanic cultural issues need attention

One final note is needed in relationship to the scope of the project and its limitation to the cultures of the most prevalent refugee groups being served by DHH. In spite of a conscientious effort to inform hospital and clinic staff about the terms of the project's grant, many people pointed out the irony of offering training on cross-cultural issues with refugees when "majority minority" issues, i.e., issues of health care access faced by African-American, Native-American and Hispanic persons, were not similarly addressed. The concern for commitment of time and resources to address these issues is entirely justified.

Culturally diverse native-born Americans deserve cross-cultural savvy

Whereas African-American or Native-American patients may not need interpreters, both may need patient advocates. It is clearly necessary to acknowledge that culturally diverse patients, whether linguistically different or not, may be confronted with cultural barriers to effective health care access in spite of language fluency. They are just as deserving of cross-culturally skillful staff who can help them make informed health care choices and access services promptly.

Trained bilingual Spanish-speaking staff are needed

It may indeed be appropriate to hire and train Spanish-speaking Interpreter/Case Managers for precisely the same roles we have described for bilingual workers serving refugee patients. It is never appropriate to ask untrained hospital employees who happen to speak the same language as patients, e.g., Spanish, to

Casual familiarity with a culture doesn't mean we know how to deliver quality care

interpret for a limited-English speaking patient of the same language background.

Everyone committed to quality health care and effective service delivery must learn about the culturally determined values and needs of all the patients they serve, whether native-born or newly arrived. The familiarity of Black, Hispanic, or Native American patients does not make their cultural issues less worthy of attention.

Community Partnerships...

Partners in a joint project model how to be a learning organization

There is an additional aspect of culture to which collaborators must pay attention—the ad hoc culture of their own project team. Especially in multicultural efforts, collaborations become experiments in quickly developing a common, project culture. Players who continually adjust to what each learns about the others' cultural idiosyncrasies stand a better chance of successfully meeting a project's goals on a timely basis.

Up-front decisions about performance measures and fiscal procedures allow partners to focus on implementation

Several fundamental elements of a workable partnership must be decided ahead of time. There needs to be a lead agency and a project coordinator from the same agency to assume responsibility for implementation and accountability for project performance to the funder or local funding conduit agency. A performance-based reimbursement scheme was developed for the DHH project contractors in order to provide both objective measures of performance and performance incentives. The project budget was organized by implementation component so that a clear, direct relationship was always apparent between what was being invoiced and a corresponding line item in the budget. Obviously, clarity about basic issues of performance and fiscal accountability "up-front" allows partners to concentrate on delivering service, not clearing up misunderstandings later.

Partners support each other in meeting the terms of their training design

Challenges which arose during implementation included the difficulty of completing training sessions on schedule and with the precise content specified in the initial implementation plan. Trainers from the community inevitably had to juggle their schedules due to unforeseen conflicts. The partners in the health care system can provide a genuine service to their community partners by helping them formulate precise plans and clear commitments. In the midst of project implementation, when schedules "get crazy," the accountability of the project team can help each of the individual players keep his or her perspective and motivation.

Solid planning is balanced with flexible accountability as implementation proceeds

Clearly, the more that can be specified, quantified, and decided before implementation begins, the easier it is to hold each other mutually accountable to an agreed upon plan when delivery is difficult. It is prudent to begin with a clear memo of understanding which implementing partners sign ahead of time, and then, as the project develops and new decisions are made, to add to this working document as additional details are specified. At the same time, it is absolutely essential for performance monitoring, whether done by a funding agency or by hospital management, to allow for the inevitable changes in focus and timing which occur when working with actual people in "real world" implementation.

A project team orchestrates a system-wide network

A project team needs to be self-conscious about its operating images. It is a temptation when organizing a new partnership to limit the representation on the team. From the start, the success of a project requires the participation of a broad

range of players who can conceptualize, plan implementation and documentation, guide impact assessment, explore continuation funding for spin-off efforts, etc. The team's operating image must shift from composer to orchestrator, i.e., from an image of involving necessary thinkers in a project's conception, to an image of coordinating a broad network of change agents who will actually do implementation. Effective facilitation can make it possible to involve sufficient people in the initial conceptual and planning work to create a comprehensive plan. Effective communication and coordination later in the project can ensure the most realistic and timely implementation.

Learning About Culture...

A long-range view opens the door to learning about other cultures present in a health care system

Broad representation in planning must be accompanied by a long-range vision in design. Cross-cultural training is gratefully received, especially by people whose ability to deliver services will be enhanced by new knowledge and access to cross-cultural expertise. But if an intensive training effort is not able to deal with all the cultures represented, a longer view must be taken in order to suggest ways in which the health care system and the community can continue to learn about culture. Without options for learning about all the cultures health care providers meet, the door is left open for resentment and charges of inequity.

Dealing with culture requires a commitment to multi-cultural competence and a willingness to continue learning

In short, the most important value of an intensive training strategy may well be the process of learning and cultural accommodation to which project partners contribute during the time they work together. An intensive cross-cultural training strategy needs to help a health care system learn how to learn about culture. This on-going learning might be formally organized and funded or it might be informally conducted and developed by interested volunteers. It might involve additional resources from the hospitals or clinics or from the community at large. Whatever form it takes, a health care system, like any prudent organization in touch with the real world, needs to clearly articulate its commitment to the multicultural competence of all its staff and its willingness to support continual cross-cultural learning.

Notes

Appendices

1. Resources

Note: the following list of resources is necessarily a limited selection of the available materials. The Spring Institute invites readers to send additional annotated references for resources they have found helpful in their work. An updated list will be made available to interested persons who send a stamped, self-addressed envelope and a check for $5.00 postage and handling to the Spring Institute.

Bibliographies

- *A Selected Bibliography on Refugee Health.*

In cooperation with the UNHCR Centre for Documentation on Refugees, July 1991. $12.90 Other titles available from the Refugee Policy Group include:

- *Promoting Mental Health Services for Refugee: A Handbook on Model Practices*, 125 pp., '91
- *Ensuring the Health of Refugee: Taking a Broader Vision*, 39 pp., '90
- *Current Trends and Developments—Contagious Disease and Refugee Protection: AIDS Policy in the United States*, 5 pp., '90
- *Health Care Options for Refugee Workers, A Manual for Service Providers in the Northeast*, 38 pp., '89
- *The Georgetown Declaration On Health Care for Displaced Persons and Refugees: An International Symposium, December 4–7, 1988.* 26 pp.
- *Community Health Centers as Providers of Refugee Health Care*, 17 pp., '83
- *The Potential for Enrolling Refugees in Health Maintenance Organizations*, 23 pp., '83
- *Medical Assistance for Refugees: Options for Change*, 37 pp., '83
- *The Refugee Health Care System: Background Paper on Policies, Programs and Concerns*, 45 pp., '82

Contact: Refugee Policy Group (RPG), 1424 16th Street, N.W., Suite 401, Washington, DC 20036. Phone: 202-387-3015 Fax: 202-667-5034

- *An Annotated Bibliography on Refugee Mental Health*

Carolyn L. Williams, Refugee Assistance Program: Mental Health—Technical Assistance Center, University of Minnesota, 1987. 335pp. (References, principally from published scientific literature, related to understanding refugees in context; specific mental health issues of refugees; and concerns for refugee children, adolescents, women, elderly, families, victims of torture and rape. Contains other bibliographic citations.) Department of Health and Human Services (DHHS)

Publication No. (ADM) 87-1515. Alcohol, Drug Abuse, and Mental Health Administration.

• *An Annotated Bibliography on Refugee Mental Health, Volume II*

Susan C. Peterson, Amos S. Deinard, and Anne List, Refugee Assistance Program: Mental Health—Technical Assistance Center, Univ. of Minnesota, 1989. Both bibliographies are available at no cost.
Contact: Refugee Mental Health Program, Attn: Barbara Duck, National Institute of Mental Health, 5600 Fishers Lane, Room 18-49, Rockville, MD 20857. Phone: 301-443-2130 Fax: 301-443-3693

• *CJF Bibliography of Resettlement Resource Materials.*

Deborah Bernick and Madeleine Tress, Ph.D. New York: Council of Jewish Federations, 1991. (A 142-page guide, principally focused on Russian Jewish emigrés, but containing resources for other major refugee language groups as well. Sections on Health and Safety and Cross-cultural Understanding.) $10 each; quantity discounts. Contact: Council of Jewish Federations, Attn: Madeleine Tress, Refugee Resettlement Department, 730 Broadway, New York, NY 10003-9596. Phone: 212-598-3525 Fax: 212-529-5842

Publications related to refugee health care

• *Health Care Options for the Working Refugee: A Manual*

Published in 1987. Available from the Department of Health and Human Services, Office of Refugee Resettlement, Washington, D.C.

• *Mental Health Services for Refugees*

Joseph Westermeyer, Carolyn L. Williams, and Ahn Nga Nguyen, Editors. DHHS Publication No. (ADM) 91-1824. Washington, D.C.: U.S. Government Printing Office, 1991. (Presentation of clinical, epidemiological, and psychological issues and models of care, processes of acculturation, and linkages with state mental health systems.) Contact: Superintendant of Documents, Mail Stop SSOP, Washington, D.C. 20402-9328.

• *Intensive Training of Bilingual Workers in Mental Health and Cross-cultural Communication*

Myrna Ann Adkins and Charles G. Ray. Denver: Spring Institute for International Studies, 1987. (Much of this manual for training bilingual mental health workers is also relevant for training bilingual health care workers.) 93 pages; cost: $22.50 including shipping and handling. Contact: Spring Institute for International Studies, 1380 Lawrence Street, Suite 600, Denver, CO 80204-2056. Phone: 303-571-5008 Fax: 303-571-5102

• *Mental Health of Immigrants and Refugees*

Wayne H. Holtzman and Thomas H. Bornemann, Editors. Austin: Hogg Foundation for Mental Health, 1990. (31 papers presented at a conference sponsored by the Hogg Foundation for Mental Health and the World Federation for Mental Health in the Spring of 1990.) 333 pages; $10.50 including shipping and handling. Contact: Hogg Foundation for Mental Health, The University of Texas, Austin, TX 78713-7998. Phone: 512-471-5041 Fax: 512-471-9608

Staff Training Videos

• *House of the Spirit: Perspectives on Cambodian Health Care*
(41 minute color video.) Contact: American Friends Service Committee, 15 Rutherford Place, New York, NY 10003.

• *Peace Has Not Been Made*
Doua Yang & John Finck. (Case history of a Hmong family's encounter with a hospital.) Rental: $35 plus $4 postage. Purchase: $75 plus $4 postage. Contact: Rhode Island Department of Human Services, Office of Refugee Resettlement, 275 Westminster Street, Providence, RI 02903. Phone: 401-277-2551

• *Providing Services with an Interpreter*
(Video developed with funding from the National Institute of Mental Health, Refugee Assistance Program-Mental Health, through the Department of Health, State of Hawaii. An informative brochure accompanying the video is a succinct checklist of how to effectively use an interpreter.) Cost: $12. Contact: Video Lab, 641 Keeaumoku Street, Suite 5, Honolulu, Hawaii 96814.
Phone: 808-947-5227 or Fax: 808-941-5606

• *Refugee Mental Health* series
(Training videos produced with funding from the Office of Refugee Resettlement through the National Institute of Mental Health. Much of what is said is relevant to general hospital settings.) Available at no cost. Contact: Refugee Mental Health Program, Attn: Barbara Duck, National Institute of Mental Health 5600 Fishers Lane, Room 18-49, Rockville, MD 20857.
Phone: 301-443-2130 Fax: 301-443-3693

- *Refugee Mental Health: Psychiatric Interviewing of R efugee Patients.* James M. Jaranson, M.D. and Noriko K. Shiota, M. Ed. University of Minnesota, Refugee Assistance Program-Mental Health Technical Assistance Center. (43 minutes)
- *Refugee Mental Health: The Importance of Primary Prevention.* Carolyn L. Williams, Ph.D., Rosa E Garcia-Peltoniemi, Ph.D., & Yossef S. Ben-Porath, University of Minnesota, Refugee Assistance Program-Mental Health Technical Assistance Center. (34 minutes)
- *Refugee Mental Health: Interpreting in Mental Health Settings.* Laurel Menhamida, M.A., Bruce Downing, Ph.D., & Eric Egli, M.A., University of Minnesota, Refugee Assistance Program-Mental Health Technical Assistance Center. (34 minutes)

• *"Refugee Counseling Skills" & Cross-cultural Counseling Skills Program for Counselors of Refugee Clients, Trainers Manual*
Tedla W. Giorgis, Ph.D. (1 hour, 47 min. videotape [VHS] and manual.) Contact: The Ethiopian Community Center, Inc.
2607 24th Street, N.W., Suite 3
Washington, D.C. 20008
Phone: 202-328-3102

• *Working With Involuntary Clients: Task Development with Depressed Clients*
University of Minnesota, University Media Resources Center. (Although intended, in the first instance, for classroom training for mental health workers, this video can be effectively used to teach task-centered case management for health workers as well.) Request information mentioning title and tape series #3962-A. Contact: U. of M. Media Resources Center, 330 21st Avenue South Minneapolis, MN 55455.

Patient Training Videos

• *Multilingual Health Education Videotapes.*
(Available in English, Spanish, Portuguese, Cambodian, Hmong, Laotian, and Vietnamese. Titles include: *A Visit to the Doctor, A Visit to the Hospital, Sexually Transmitted Diseases, Hepatitis B, Tuberculosis, Prenatal Care for You and Your Baby, Taking Care of Yourself After Delivery, Taking Care of Your Newborn Baby,* and *Lead Poisoning*.) Cost: 1st tape $45.00, 2nd tape $40; additional tapes $35. Request order form. Contact: Patient Education Department, Women and Infants Hospital of Rhode Island, 101 Dudley Street, Providence, RI 02905-2499. Phone: 401-274-7410

Training resources for staff serving Russian-speaking patients

• *Medications Commonly Prescribed in the USSR—an ongoing project*
Joan M. Schulhoff, PA-C, et al. Jewish Federation of Metropolitan Chicago, revised 12/91. (A 50-page compendium-in-process, listing major medications used in the Soviet medicine, their names in Russian and English, U.S. equivalents, known indications in Soviet medical practice, additional information from Russian texts, and other comments. To be updated as addition information becomes available.) Available at no cost. Contact: Jewish Federation of Metropolitan Chicago, Ben Gurion Way, 1 South Franklin Street, Chicago, IL 60606-4694. Phone: 312-346-6700 Fax: 312-444-2086

• *A Medical Vocabulary/Phrase Booklet for Non-Russian Speaking Health Care Providers*
Joan M. Schulhoff, PA-C, et al. Jewish Federation of Metropolitan Chicago, '90.
(A 21-page Russian/English list of common medical and general terms and useful Russian phrases. Includes symptoms, diagnoses, health care terms, lab terms, anatomy, foods and beverages.) Available at no cost from the Jewish Federation of Metropolitan Chicago.

Training resources for staff serving Southeast Asian patients

• *Medical Guide: An Introduction to Medical Services in North America* ($7.50)
• *Medical Glossary: A Phrasebook for Bilingual Health Care* ($5.50)
• *Medical Guide and Medical Glossary* (Set: $12.00)
(English, with Cambodian, Laotian, and Vietnamese words.) Contact: International Refugee Center of Oregon, 1336 E. Burnside Street, Portland, OR 97214. Phone: 503-234-1541

• *California Southeast Asian Mental Health Needs Assessment*
Elizabeth Gong-Guy, Ph.D. Oakland, California: Asian Community Mental

Health Services, 1987. (A classic training resource and example of a comprehensive needs assessment containing useful information about Southeast Asian refugees. Documents the relationship between cultural adjustment/mental health issues and somatic complaints.) Potentially available in university, large public libraries, or refugee mental health workers' files.

• *Southeast Asian Mental Health: Treatment, Prevention, Services, Training, and Research*

Tom Choken Owan, ACSW, Editor. U.S. Department of Health and Human Services, 1985. DHHS Publications No. (ADM) 85-600553. 559 pages.

(An indexed compendium of articles on treatment, prevention, services, training, and research relating to mental health care for Southeast Asians.) Available at no cost. Contact: Refugee Mental Health Program, Attn: Barbara Duck, National Institute of Mental Health, 5600 Fishers Lane, Rm. 18-49, Rockville, MD 20857. Phone: 301-443-2130 Fax: 301-443-3693

• *A Mutual Challenge, Training and Learning with the Indochinese in Social Work, A Manual for Supervisors and Trainers*

Edited by Kathleen H. Lique, Training Center for Indochinese Paraprofessionals. Boston: Boston University School of Social Work, Division of Continuing Education, 1982. (A comprehensive reference for training Southeast Asian workers with sections on bi-cultural paraprofessionals, cross-cultural adult education, and curricula. The Appendix contains a comparison of Southeast Asian cultures, resource list, and a training program description.) Cost: $15.

• A 60 page *Casebook* is available to accompany *A Mutual Challenge*. (Eight case studies, questions for discussion and a bibliography) Cost: $7.50. Order either or both books by phone or mail, payment by Visa/MasterCard.
Contact: B.U. School of Social Work, Division of Continuing Education,
1 University Road, Boston, MA 02215. Phone: 617-353-3756

Articles on health care with Southeast Asian patients

• Lin-Fu, Jane S., "Meeting the Needs of Southeast Asian Refugees in Maternal and Child Health and Primary Care Programs." *MCH Technical Information Series*, March, 1987.

• Mueke, Marjorie A., "In Search of Healers: Southeast Asian Refugees in the American Health Care System." *The Western Journal of Medicine*, 139 (6): 835-840, December, 1983.

• Nguyen, Maj. Duong, "Culture Shock—A Review of Vietnamese Culture and Its Concepts of Health and Disease." *The Western Journal of Medicine*, 142 (3): 409–412, March, 1985.

Resources for Russian-speaking patients

• *Health the American Way*

Joan M. Schulhoff, PA-C, et al. Jewish Federation of Metropolitan Chicago, '90. (A 170-page Russian-English guide to visiting a doctor, medicines in the home, paying for health care, American dentistry, women's issues, American-style eating, and diabetes. Published in association with Mount Sinai Hospital

Medical Center of Chicago.) $10, pre-paid, includes postage and handling. Contact: Jewish Federation of Metropolitan Chicago

• *Diabetes Handbook*
Joan M. Schulhoff, PA-C, et al. Jewish Federation of Metropolitan Chicago, '88. (A 71-page Russian-English guide to understanding and treating Diabetes. Contains sections on proper diet, insulin therapy, urine testing, and exercise. Published in association with Mount Sinai Hospital Medical Center of Chicago.) Available at no cost from the Jewish Federation of Metropolitan Chicago.

Refugee Resettlement Guide

• *Guide to Resettlement in the United States*
(130 page general overview of the resettlement process with specific sections on employment, education, holidays, etc. Available in English, Russian, Farsi, Polish, Czech, Armenian, Rumanian, Hungarian, and Kurdish.) Complimentary copies available to resettlement agencies, etc. Contact: The Center for Applied Linguistics (CAL), 1118 22nd Street, N.W., Washington, D.C. 20037. Phone: 202-429-9292

2. Networking

State "Refugee Guides"

• States or local agencies serving refugees may have published various guides and directories. (Note, for example, The Colorado Refugee and Immigrant Services Program (CRISP) 1987 publication, *Living In Colorado, a guide for refugees*. The 40 page book contains suggestions for coping with resettlement and a listing of many of the resources available to refugees in Colorado.) Whereas such publications may be out of print, they should still be in refugee service providers' files and could be a useful starting point for identifying potential partners in a collaborative cross-cultural training effort.

State refugee agencies; public sector "Program Specialists"

• *State Refugee Coordinators and other public sector refugee specialists*
All states have had Refugee Coordinators for over a decade, since the passage of the Refugee Act of 1980. Some states used federal funds to create centralized refugee service agencies, others to fund more locally autonomous programs. In addition, Departments of Social Services, Health, Mental Health, and Institutions, or their equivalents, have staff Program Specialists who may have devoted much of their time over the last decade to providing technical assistance to, and in some cases, funding for, projects related to refugee health. These public sector people are a potential entrée to the network of people knowledgeable about refugees, appropriate services, and cross-cultural training.

• *State and County Departments of Health*
Cross-cultural expertise specifically related to health care access may also be available in Departments of Health staff, e.g., the Refugee Health Care Access Program of the Colorado Department of Health. A state Epidemiology Division

might have a Refugee Public Health Disease Control Specialist available for consultation and training on the cross-cultural aspects of dealing with infectious diseases of public health concern, e.g. tuberculosis. Refugee health care specialists with experience in maternal and child health or other specific areas may be available at the state and/or county levels.

Refugee Assistance Program —Mental Health

• *Refugee Assistance Program-Mental Health (RAP-MH)*

In the mid-eighties, the Office of Refugee Resettlement funded a project to facilitate culturally appropriate mental health care services for refugees. The project was implemented by the National Institute of Mental Health Refugee Mental Health Program in twelve states (Washington, California, Texas, Colorado, Minnesota, Wisconsin, Illinois, Massachusetts, New York, Rhode Island, and Virginia) and included a Technical Assistance Center at the University of Minnesota. People who participated in these projects have information and skills related to providing culturally appropriate services in general hospitals and clinics as well as mental health centers.

Peter Van Arsdale, Ph.D. is an example of this kind of knowledgeable resource. Dr. Van Arsdale wrote an article which appeared in the *New England Journal of Human Services*, (1988, Volume VIII, Issue 2), entitled "Mainstreaming Mental Health Services to Refugees." The article describes a process for planning the mainstreaming of services for refugees in a mental health context. The ten "success factors" identified are broadly relevant. Contact: Dr. Van Arsdale, Coordinator, Colorado Refugee Assistance Program-Mental Health, Division of Mental Health, 3520 W. Oxford Avenue, Denver, CO 80236.
Phone: 303-762-4094 Fax: 303-762-4373

3. Training Partners

Cultural Awareness Training

- Myrna Ann Adkins, Spring Institute for International Studies
- Sumiko Hennessy, Asian/Pacific Center for Human Development
- Inna Porotova-Adler, Spring Institute for International Studies
- Jae Wha Ahn, Asian/Pacific Center for Human Development
- D. J. Ida, Asian/Pacific Center for Human Development
- Van Lam, Colorado Department of Health
- Jan Reimer, Colorado Department of Health
- Hue Vi, Colorado Department of Health
- Pajhoua Yang, Colorado Department of Health

Intensive Case Management Trainings

- Myrna Ann Adkins, Spring Institute for International Studies
- Inna Porotova-Adler, Spring Institute for International Studies
- Dennis Kennedy, Spring Institute for International Studies
- Walter Hoan Nguyen, East Dallas Counseling Center/Dallas Challenge
- Charles G. Ray, National Council of Community Mental Health Centers
- Yana Vishnitsky, Jewish Family Service

Community Health Care Access Training

- Inna Porotova-Adler, Spring Institute for International Studies
- Rosalie Dam, Denver Health and Hospitals
- Onechanh Inthamanivang, Asian/Pacific Center for Human Development, Lao Lu Association
- Senait Ketema, Colorado Refugee and Immigrant Services Program, Spring Institute, and Ethiopia Women's Group
- Anwar Necko, Spring Institute for International Studies, Afghan Relief Association
- Lan Nguyen, Asian/Pacific Center for Human Development
- Valery Saminsky, Denver Health and Hospitals
- See Thao, Denver Health and Hospitals
- Kim Tim, Denver Health and Hospitals
- Marilyn Ung, Asian/Pacific Center for Human Development, Khmer Association
- Maysee Yang, Asian/Pacific Center for Human Development, Hmong Women's Association